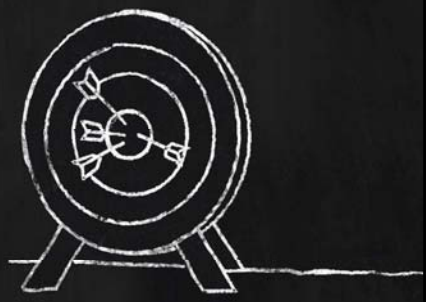
Critical Access Hospital and
Rural Health Clinic Conference

A Deep Dive:
Your Medicare Cost Report From A-M

May 3, 2017



WIPFLI LLP
CPAs and Consultants
HEALTH CARE PRACTICE

Introduction to Health Care Reimbursement

If a non-health care business charges $100 for a good or service it provides, how much does it get paid?


Gas Station


Grocery Store


Plumber

Restaurant


Garbage Service


Clothing Store

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Introduction to Health Care Reimbursement

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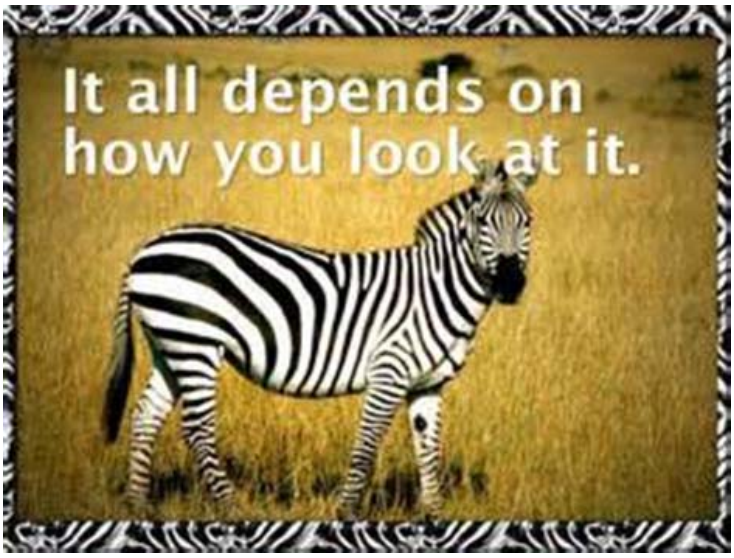
If a health care provider charges $100 for a service it provides, how much does it get paid?

Introduction to Health Care Reimbursement



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Introduction to Health Care Reimbursement

Examples of Possible Payments for Health Care Services

Private pay	$ 100
Private pay	-
Medicare	60
Medicaid	55
Insurance #1	90
Insurance #2	85
Insurance #3	80
Etc.	?

To determine the estimated amount a health care provider will be paid, three important pieces of information must be known:

1. Payor type
2. Patient type
3. Specific type of service

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Introduction to Health Care Reimbursement

Sample Methods of Reimbursement Currently in Use in the Health Care Industry

Hospital

- Medicare
  - "Allowable" cost
  - Diagnosis related groups (DRGs)
  - Fee schedules
  - Add-on payments
  - Ambulatory procedure codes (APCs)
- Medicaid
  - Cost-based rates
  - Access payments
  - Fee schedules
  - Enhanced ambulatory procedure groups
- Commercial insurance
  - Contracted payors
    - Negotiated discounts
    - Rates per visit
    - Fee schedules
  - Noncontracted payors
    - Standard charges
- Self-pay patients
  - Standard charges
  - Discounts as required under "Patient Protection Act" or state specific legislation
  - Charity care
  - Bad debts

Nursing Home

- Medicare
  - Resident Utilization Groups (RUGs)
  - Fee schedules (therapy)
  - "Allowable" cost for vaccines
- Medicaid
  - Blended cost and acuity-based rates
  - Fee schedules (therapy)
- Commercial insurance
  - Standard charges
  - Negotiated rates
- Self-pay patients
  - Standard charges

Psych/Acute Rehab Services

- Medicare
  - Diagnosis-related groups (inpatient)
  - "Allowable" cost
  - Fee schedules
- Medicaid
  - Cost-based rate per discharge (inpatient)
  - Fee schedules
- Commercial insurance
  - Contracted payors
    - Negotiated discounts
    - Rates per visit
    - Fee schedules
  - Noncontracted payors
    - Standard charges
- Self-pay patients
  - Standard charges
  - Discounts as required under "Patient Protection Act" or state specific legislation
  - Charity care
  - Bad debts

Home Health/Hospice

- Medicare
  - Rates per episode of care or length of stay
- Medicaid
  - Rates per episode of care or length of stay
- Commercial insurance
  - Standard charges
  - Negotiated rates
- Self-pay patients
  - Standard charges

Clinics

- Medicare
  - Fee schedules
  - "Allowable" cost for rural health clinics
- Medicaid
  - Fee schedules
  - "Allowance" cost or per diem rates for rural health clinics
- Commercial insurance
  - Contracted payors
    - Negotiated discounts
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Medicare Reimbursement

There are two primary types of hospital reimbursement methodologies for Medicare

- Prospective Payment System (PPS)
- Cost-Based System

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Prospective Payment System - Hospital Services

Medicare

- Inpatient and Outpatient
  - Paid at prospectively determined rates based on a patient classification system
    - Inpatient => MS DRG
    - Outpatient => APCs
  - Payment calculation: Base rate x weight
  - Example: Chest pain, DRG 143, relative weight .5391 (per Federal Register)
    $5,000 x .5391 = $2,695

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Cost-Based System - Hospital Services

Medicare

- Inpatient, Outpatient, and Swing Bed
  - Generally, paid for services based on (retrospective) cost reimbursement methods.
  - Although certain types of laboratory services, ambulance services, and professional services may be carved out and reimbursed using a prospectively determined fee schedule.

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Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Inpatient	DRG	101% of Allowable Cost
Outpatient Procedures (surgery, radiology, etc.)	APC	101% of Allowable Cost
Lab	Fee Schedule	101% of Allowable Cost (except for reference lab)
Therapies	Fee Schedule	101% of Allowable Cost
Swing Bed	RUG	101% of Allowable Cost
Ambulance Service	Fee Schedule	Fee Schedule (unless only one within 35 miles, then 101% of cost)

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Medicare Payment Overview

Type of Service	PPS Hospital	CAH
O/P Clinics (facility component)	APC	101% of Allowable Cost
O/P Clinics (professional component)	Fee Schedule (reduced for site of service)	Fee Schedule Plus 15% for CAHs Electing Method II Billing (reduced for site of service)
CRNA Services	Fee Schedule (unless elect cost if less than 800 procedures/year)	Fee Schedule (unless elect cost if less than 800 procedures/year and 1 FTE/year)
Other Professional Services	Fee Schedule – Except for professional services in a rural health clinic, then generally based on allowable cost	Fee Schedule Plus 15% for CAHs Electing Method II Billing (except for professional services in a rural health clinic setting, then generally based on allowable cost)
Outlier Payments	Cost – Generally insignificant for rural providers	N/A

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Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Disproportionate Share Hospital (DSH)	Add-on to DRG payments	N/A
Graduate Medical Education (GME)/ Indirect Medical Education (IME)	Add-on to DRG payment	If approved, included in 101% of allowable cost
Exempt Units	Rehab Unit – PPS Psych Units – PPS	Limited to 10 exempt unit beds (Same reimbursement as PPS)

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Medicare Payment Overview

Type of Service	PPS Hospital	CAH
Skilled Nursing Facility	RUGs	RUGs
Home Health Agency	HHRGs	HHRGs
Hospice	Prospective rate	Prospective rate
Dialysis	Prospective rate	Prospective rate, except inpatient dialysis is 101% of allowable cost

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Acronyms

PPS	-	Prospective Payment System
CAH	-	Critical Access Hospital
DRG	-	Diagnostic Related Group
APC	-	Ambulatory Payment Classification
MDS	-	Minimum Data Set
RUGs	-	Resource Utilization Groups
HHRG	-	Home Health Resource Group

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Medicare Cost-Based Reimbursement

Medicare reimbursement =
101% of Medicare allowable cost

Effective April 1, 2013, there is also a governmental budget sequestration adjustment of a 2% reduction in reimbursement after determining deductible and coinsurance amounts applicable to all Medicare claims. (Currently, the sequestration adjustment is projected to continue through 2023.)

Currently, there is legislative discussion by CMS to reduce reimbursement from the current 101% to 100% of Medicare allowable cost before sequestration.

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Medicare Cost-Based Reimbursement Overview

What is "allowable" cost?

- Necessary and proper in providing services
- Must be related to patient care (includes personnel costs, administrative costs, laundry, housekeeping, dietary, etc.)
- Adequate cost data and cost finding support
- Must be "reasonable"; i.e., must follow the ***"prudent buyer"*** principle

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Medicare Cost-Based Reimbursement Overview

What is the prudent buyer principle?

- The prudent and cost-conscious buyer not only refuses to pay more than the going (market) price for an item or service, he/she also seeks to economize by minimizing cost.
- This is especially so when the buyer is an institution or organization that makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases.
- Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices.
- Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

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Medicare Cost-Based Reimbursement Overview

Computation of "allowable" costs:

- Allowable cost = Total expense *minus* costs not supported by Medicare *minus* cost offsets.
- Examples of costs not supported by Medicare: some forms of advertising expense, bad debt expense, lobbying dues, etc.
- Examples of cost offsets: some forms of investment income, other operating revenue such as vending machine income, medical records fees, etc.

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Allowable Cost Summary Based on Year End, 20XX, Medicare Cost Report

Sample Hospital FYE XX/XX/20XX Cost Report Information:

Total expenses		**$ 46,000,000**
Add: Related-party add-on	$ 2,500,000	
Less: Medicare nonallowable expenses:		
Provider-based physicians	(2,400,000)	
Investment income	(10,000)	
Cafeteria	(165,000)	
Unnecessary borrowing - Nonallowable interest expense	(500,000)	
Electronic health records system depreciation	(175,000)	
Other miscellaneous revenue	(250,000)	
Subtotal		(1,000,000)
Allowable expenses		45,000,000
Less - Noncost reimbursed expenses:		
Nursing home and assisted living	(6,000,000)	
Marketing	(800,000)	
Specialty clinic	(1,200,000)	
Subtotal		(8,000,000)
Total cost reimbursed expenses		**$ 37,000,000**

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High Level View Computation of Medicare Cost-Based Reimbursement

Inpatient and Swing Bed

- Nursing services costs component – Routine Costs

plus

- Ancillary costs component (computed for each department)

Outpatient

- Ancillary costs component (computed for each department)

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High Level Understanding of Dollar Impact on Reimbursement

Patient-Related Expense Example:	
Adults and Pediatrics Medicare Utilization	75%
Increase Adults and Pediatrics Allowable Expense by	$ 100,000
Dollar Impact on Medicare Reimbursement	$ 75,000
Expenses to be paid from sources other than Medicare	$ 25,000
Overhead Expense Example:	
Increase Laundry Expense by	$ 100,000
Percent of Total Cost That is Cost Reimbursed	72%
Estimated Medicare Allowable Expense	$ 72,000
Average Medicare Utilization	44%
Dollar Impact on Medicare Reimbursement	$ 31,680
Expenses to be paid from sources other than Medicare	$ 68,320

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Common Myths About CAH Status

CAH Myths:

All costs will get paid . . .

All Medicare allowable costs for Medicare enrollees will get paid . . .

We're a critical access hospital; therefore, we should *always* "break even" . . .

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Common Fact About CAH Status

CAH Fact:

You can't make a profit from Medicare.

Where do we go from here?

Cost Report Layout

Worksheet number is at top right-hand corner of each worksheet.

Worksheet Series	
S	Settlement, Organization, and Patient Statistical Information
A	Expense Assignment
B	Allocation of Overhead Costs
C	Patient Care Revenue and Cost-to-Charge Ratio
D	Determination of Medicare's Costs
E	Medicare Settlement and Payment Information
G	Financial Statements
H	Home Health
I	Renal Dialysis
K	Hospice
M	Rural Health Clinic

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Basic CAH Medicare Cost Report Mechanics

Worksheet S	Worksheet A	Worksheet B	Worksheet C	Worksheet D	Worksheet E
Informational Questions	Expenses	Overhead expense allocation	Charges	Medicare/ Medicaid Charges	Medicare/ Medicaid Settlement
S, S-2, S-3, S-4, S-5, S-7, S-8, S-9, S-10	A, A-6, A-8, A-8-1, A-8-2, A-8-3	B Part I, B-1	C	D Part V, D-3, D-1 Parts I, II, III	E Part B, E-1, E-2 E-3 Part V
Hospital information, patient days, and other statistics	Costs reclassified, added, and subtracted	Overhead allocated to revenue-producing departments	÷ Dept. revenues = Cost-to-charge ratios	X Dept. Medicare charges = Medicare cost	Compared to Medicare Payments = Settlement

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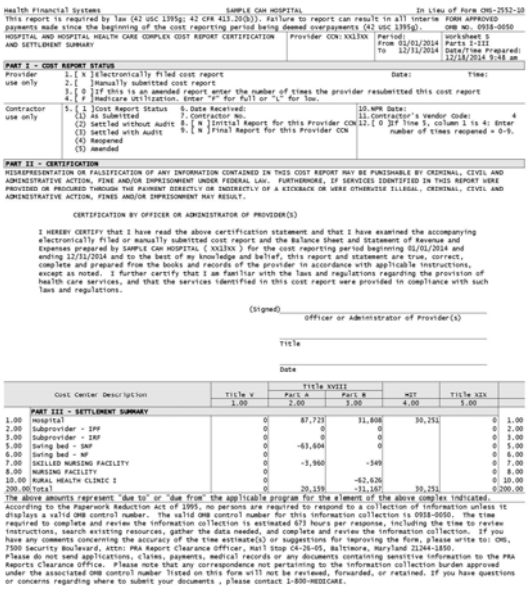
Worksheet S

Worksheet S

- Cost report settlement worksheet
- Must be signed by officer/ administrator
- Title XVIII Part A and Part B are added together to determine total settlement receivable or payable
- HIT (Health Information Technology) column is informational and will be settled at a different time than the Medicare cost report



Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY — Provider CCN: XX1IXX — Period: From 01/01/2014 To 12/31/2014 — Worksheet S Parts I-III Date/Time Prepared: 12/18/2014 9:48 am

PART I - COST REPORT STATUS

Provider use only:
1. [X] Electronically filed cost report
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "P" for full or "L" for low.

Date: Time:

Contractor use only:
5. [1] Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Reopened
(5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAMPLE CAH HOSPITAL (XX1IXX) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____ Officer or Administrator of Provider(s)

Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	87,723	31,808	30,251	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-63,604	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-3,960	-349		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		-62,626		0	10.00
200.00	Total	0	20,159	-31,167	30,251	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Worksheet S-2

Worksheet S-2, Part I

- Series of informational questions that provide the cost report "reader" with a wealth of knowledge about the hospital.
  - Provider type and payment system
  - Debt and lease agreements
  - Provider-based physician services
  - Statistical basis
  - Contract therapy
  - Reimbursable bad debts
  - Provider summary report data
- Important to ensure all responses are accurate because they can directly impact the settlement (i.e., data may not flow to a worksheet if the response on worksheet S-2 is not accurate, which may directly impact the final cost report settlement).

Worksheet S-2, Part I

Key lines for CAHs include:

26	Geographic location
90-97	Title V and Title XIX
105	Critical access hospital
106	Elected all-inclusive for O/P services (Method II)
108	CRNA pass-through (rural election only)
109	Purchased PT, OT, ST & RT

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	109.00

Worksheet S-2, Part I

Key lines for CAHs include:

118	Malpractice policy type & amounts
140	Related-party activity
144	Provider-based physicians
146	Change in allocation method
167-170	HIT meaningful use

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	16
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	450,000	16
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	16

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/15/2013	08/13/2013	17

Elections - All-Inclusive/Method II Billing

- Worksheet S-2 Part 1 Line 106

  If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services?

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Elections - All-Inclusive/Method II Billing

- What is Method II Billing?
  - Combined billing on an 851 claim form that includes both facility and outpatient professional service charges
    - Facility payment continues to be 101% costs (subject to sequestration)
    - Payment for professional services at 115% of Medicare fee schedule after Part B deductible and coinsurance (Note: CPT/HCPCS code required)

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Elections - All-inclusive/Method II Billing

- How to make the all-inclusive/Method II billing election:
  - One-time election must be made in writing to Medicare contractor
  - Election stays in effect until hospital withdraws
  - Must be filed 30 days before beginning of cost report year
  - Applies to physician services in outpatient space, where physician reassigns billing to CAH, in a provider-based department, other than a provider-based rural health clinic, for example:
    - Pathology
    - Emergency room
    - Outpatient clinics
    - Radiology
    - Outpatient surgery

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Elections - All-inclusive/Method II Billing

- Does not include rural health clinic services or inpatient professional services (does include outpatient observation services)
- Cannot elect mid-year for new physicians that are outside of the departments for which you did elect Method II
- Can elect all-inclusive/Method II billing for CRNA services (usually not advisable if already receiving CRNA pass-through)

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Elections - Additional Bonuses Available

- The following bonuses are available for physician billing:
  - Additional payment for HPSA Bonus (10%)
  - Additional incentive payment for primary care practitioners (10%) (per ACA)
  - Additional incentive payment for rural surgeons (10%) (per ACA)
  - Telemedicine add-on for eligible site of origination of visit for qualifying telemedicine services (approximately $25 per service/visit)

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Election - CRNA Pass-Through

- Worksheet S-2, Line 108

  Is this a rural hospital qualifying for an exception to the CRNA fee schedule?

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Election - CRNA Pass-Through

- What is the CRNA Pass-Through (i.e., exception to fee schedule)?
  - Cost-based reimbursement for anesthesiology services provided by a CRNA, if you are a low volume provider

Elections - CRNA Pass-Through

Criteria for qualification:

- Perform less than 800 surgeries per calendar year requiring anesthesia
- CRNA has less than 2,080 hours of worked time
- Qualifying criteria determined by annualizing procedures and hours through September 30
- Must be in rural county
- Hospital must have been in existence in calendar year 1987 and procedures in that year did not exceed 250 procedures performed by the CRNA
- Annual calendar year election
- Must make a written request between October 1 and November 30 of each calendar year

Worksheet S-3

Worksheet S-3, Part I

Reporting of statistical data:

- Number of beds
- CAH hours for I/P care, excluding swing bed, nursing home, and observation
  - Critical data along with discharges used to calculate average length of stay for 96-hour rule compliance
  - Important to track hours and not merely use days times 24 hours
- Patient days
  - Report by payor type – Medicare and Medicaid
  - Report total days
- FTEs
- Discharges

Worksheet S-3, Part I

- Observation days (be sure to track where observation is occurring in the hospital and maintain logs)
- Discharges (no impact on settlement)

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Worksheet S-3, Part I: Patient Days and Discharges

Assuming cost remains constant

↑ Patient Days =	↓ Routine Cost per Day
↑ Patient Days =	↓ Routine Cost Reimbursement per Day
↑ Patient Days =	↑↓ Profit per Day on Non-Medicare Days (until reach "break-even" payor mix)

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Cost Reporting Strategies

- Accurate patient days are critical for a CAH for proper cost-based reimbursement and also for cost report optimization due to several cost reporting rules and regulations.
- Formula for routine costs and cost reimbursement calculation for inpatient services:

$$\frac{\text{IP Routine Direct Costs} \pm \text{Adjustments and Reclassifications} + \text{Overhead Allocated}}{\text{Adults \& Peds Days} + \text{Swing Bed-SNF Days} + \text{Observation Days Equivalent}} = \text{Routine Cost Per Day}$$

- Medicare Inpatient Routine Reimbursement Calculated as:

Routine Cost Per Day X 101% (CAH Reimbursement rate) X 98% (Sequestration after factoring deductible and coinsurance amounts) = Medicare CAH Inpatient Routine Reimbursement Per Day

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Cost Reporting Strategies

Question: How Difficult Is it to Count Patient Days for Cost Reporting Purposes?

Answer: It can be difficult due to many variables. Accurate payment days are critical to ensure proper cost calculations in the cost report.

Guiding Principle: Medicare reimbursement for inpatient and swing bed services is based on allowable costs in the inpatient nursing unit divided by number of "acute inpatient days."

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Cost Reporting Strategies

Worksheet S-3 Part I: Patient Days and Discharges

To ensure accuracy of patient days:

- Eliminate labor and delivery days
- Count SNF and NF swing bed days separately
  - Per cost report instructions, SNF swing bed days are defined as traditional swing bed days plus HMO swing bed days
- Hospice days - If the CAH has a contractual relationship for hospice services:
  - Do not include contracted hospice days on Worksheet S-3
  - Do not include contracted hospice charges on Worksheet C
  - Offset contracted hospice revenue via Worksheet A-8 adjustment to the cost center, which includes the expenses for providing the contract hospice services
- Other days – Ensure that adults and pediatrics days do not include days such as respite care or "bed and breakfast" days where acute care services are not being provided (Consider reporting these as NF days)

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Cost Reporting Strategies

To ensure accuracy of patient days (Continued):

- How do we gather information for observation days?
  - Ensure observation days are based on hours of service divided by 24
  - Always round up to the next whole observation day when calculating observation day equivalents

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Patient Days Exercise

Worksheet S-3, Part I, Column 8

		Total All Patients
Line 1	Hospital Adults & Peds	1,320
Line 5	Hospital Adults & Peds - Swing Bed SNF	200
Line 28	Observation Bed Days	80
	Total Days	1,600

Patient Days Exercise

Med Surg Days	850	
Obstetric Days	365	
Labor & Delivery Days	35	
Hospice Days	50	
Respite Days	20	
Total Hospital Adults & Peds	1,320	A
Swing Bed SNF	120	
Swing Bed NF	80	
Total Hospital Adults & Peds - Swi	200	A
Observation Units	80	A
Observation Days	25	
Total Days	1,600	Sum of A

Worksheet S-3, Part I, Column 8

		Total All Patients
Line 1	Hospital Adults & Peds	_____
Line 5	Hospital Adults & Peds - Swing Bed SNF	_____
Line 6	Hospital Adults & Peds - Swing Bed NF	_____
Line 28	Observation Bed Days	_____
Line 32	Labor & Delivery Days	_____

Tips on Where to Focus Efforts

Example of estimated impact of change in patient days:

	Adults & Peds	
Medicare adults & peds plus SNF swing bed days	750	750
Total adults & peds plus SNF swing bed plus observation days	1,600	1,360
Medicare Utilization	**46.9%**	**55.1%**
Adults & Peds reimbursable costs	$ 2,000,000	$ 2,000,000
Medicare reimbursable costs	$ 938,000	$ 1,102,000
Change in Medicare reimbursable costs		$ 164,000

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Other S Worksheets

S-3, Part II-V	Wages and hours (CAHs generally exempt from reporting unless required by state Medicaid program)
S-4	Home health data
S-5	Renal dialysis data
S-7	SNF RUG data
S-8	RHC data
S-9	Hospice data
S-10	Hospital Uncompensated and Indigent Care Worksheet

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Worksheet A

Worksheet A Columns

Column 1	Salaries
Column 2	Other expenses
Column 4	Reclassifications flow from Worksheet A-6
Column 6	Adjustments flow from Worksheet A-8
Column 7	Net allowable costs (to Worksheet B)

Worksheet A Lines

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES — Provider CCN: XX13XX — Period: From 01/01/2014 To 12/31/2014 — Worksheet A — Date/Time Pre 12/18/2014 9:

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expenses For Allocation	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
		GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,400,000	1,400,000	150,000	1,550,000	-20,000	1,530,000	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	600,000	600,000	-75,000	525,000	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,000,000	2,000,000	0	2,000,000	0	2,000,000	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,100,000	1,100,000	2,200,000	0	2,200,000	-65,000	2,135,000	5.00
7.00	00700	OPERATION OF PLANT	200,000	500,000	700,000	0	700,000	0	700,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	75,000	10,000	85,000	0	85,000	0	85,000	8.00
9.00	00900	HOUSEKEEPING	275,000	60,000	335,000	0	335,000	0	335,000	9.00
10.00	01000	DIETARY	200,000	430,000	630,000	0	630,000	-30,000	600,000	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	0	0	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	500,000	130,000	630,000	0	630,000	0	630,000	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	920,000	100,000	1,020,000	0	1,020,000	-100,000	920,000	30.00
44.00	04400	SKILLED NURSING FACILITY	1,380,000	100,000	1,480,000	0	1,480,000	0	1,480,000	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	200,000	400,000	600,000	0	600,000	0	600,000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,000	700,000	960,000	0	960,000	0	960,000	54.00
60.00	06000	LABORATORY	300,000	480,000	780,000	0	780,000	0	780,000	60.00
66.00	06600	PHYSICAL THERAPY	300,000	100,000	400,000	0	400,000	0	400,000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,000	100,000	140,000	0	140,000	0	140,000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,000	750,000	1,000,000	0	1,000,000	0	1,000,000	73.00
		OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,000,000	600,000	1,600,000	0	1,600,000	0	1,600,000	88.00
91.00	09100	EMERGENCY	1,200,000	100,000	1,300,000	0	1,300,000	-400,000	900,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92.00
		SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		750,000	750,000	-750,000	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,120,000	9,810,000	17,930,000	0	17,930,000	-690,000	17,240,000	118.00
		NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,000	0	30,000	0	30,000	0	30,000	190.00
200.00		TOTAL (SUM OF LINES 118-199)	8,150,000	9,810,000	17,960,000	0	17,960,000	-690,000	17,270,000	200.00

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Worksheet A Lines

Departments organized by:

- General service cost centers (Lines 1 to 23) - *Administration, plant, employee benefits, housekeeping, etc.*
- Inpatient routine service cost centers (Lines 30 to 46) - *Adults and pediatrics, SNFs, etc.*
- Ancillary service cost centers (Lines 50 to 76) - *Laboratory, radiology, pharmacy, etc.*
- Outpatient service cost centers (Lines 88 to 93) - *Provider-based clinics, emergency room (ER), observation*
- Other reimbursable cost centers (Lines 94 to 101) - *Dialysis, DME, ambulance, home health*
- Special purpose cost centers (Lines 105 to 117) - *ASC and hospice*
- Non-reimbursable cost centers (Lines 190 to 194) - *Gift shop, adult day care, medical office building, free standing clinic, research, etc.*

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Cost Reporting Strategies

Worksheet A

- Reconcile expenses by department to internal and/or audited financial statements
- Evaluate prescribed cost centers and identify opportunities to expand or collapse cost centers/departments (i.e., therapies)
- Review non-reimbursable cost centers/departments to determine if expenses can be directly assigned or reduced
- Compare expense by department to prior year – explain changes to ensure expenses properly recorded in each cost center/department

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Worksheet A-6

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Worksheet A-6

- Worksheet A-6 – Provides opportunity to reclass expenses between cost centers/departments to provide for proper matching of expenses with revenue
- Could result in converting hospital expense groupings to Medicare groupings
- Common reclassifications:
  - Interest expense
  - Depreciation expense
  - Nursing salaries
  - Physician activities (i.e., benefits, rounding)

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Worksheet A-6 - Common Reclassifications

- Try to keep number of reclassifications to a minimum

Health Financial Systems | SAMPLE CAH HOSPITAL | In Lieu of Form CMS-2552-10
RECLASSIFICATIONS | Provider CCN: XX13XX | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/18/2014 9:48 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASSIFY INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	750,000	1.00
	TOTALS		0	750,000	
	B - RECLASSIFY DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	600,000	1.00
	TOTALS		0	600,000	
500.00	Grand Total: Increases		0	1,350,000	500.00

Health Financial Systems | SAMPLE CAH HOSPITAL | In Lieu of Form CMS-2552-10
RECLASSIFICATIONS | Provider CCN: XX13XX | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/18/2014 9:48 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASSIFY INTEREST					
1.00	INTEREST EXPENSE	113.00	0	750,000	11	1.00
	TOTALS		0	750,000		
	B - RECLASSIFY DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	600,000	9	1.00
	TOTALS		0	600,000		
500.00	Grand Total: Decreases		0	1,350,000		500.00

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Cost Reporting Strategies

Worksheet A-6 (Reclassifications)

- Where do we want to reclass expense if possible?
  - Cost centers/departments with:
    - High Medicare utilization or
    - Low Medicare utilization

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Cost Reporting Strategies

Determine $150,000 of expenses were incorrectly coded to RAD (Medicare utilization 30%) and should have been recorded in PT (Medicare utilization 50%).

What do you think the estimated reimbursement impact is?

A. $30,000

B. $45,000

C. $75,000

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Cost Reporting Strategies

Determine $150,000 of expenses were incorrectly coded to RAD (Medicare utilization 30%) and should have been recorded in PT (Medicare utilization 50%).

Reimbursement impact is at least $30,000 based on increase in utilization.

- Increase in Medicare utilization 20% (50% - 30%) times $150,000

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Worksheet A-8

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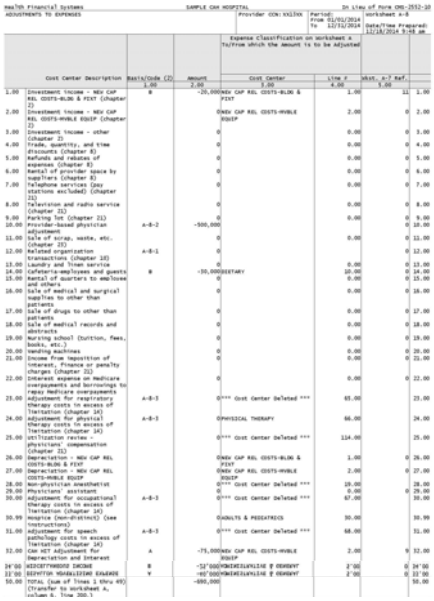
Worksheet A-8: Adjustments to Expenses

- This worksheet provides for adjustments to remove unallowable expenses and offset nonpatient care revenue
- Adjustments increase or decrease reimbursable costs
- Medicare assumes that nonpatient service revenue is equal to the cost of the service provided
- Review all nonpatient income to determine if an offset to expense is required



Worksheet A-8 - Adjustments

Potential A-8 revenue offsets:	Potential A-8 expense offsets:
Realized investment income (funded depreciation)	Interest expense (unnecessary borrowing)
Cafeteria revenue	Refinancing costs
Rebates	Patient phones and cable TV
Hospital assessments	Lobbying costs (portion of association dues)
Medical record fees	CRNA cost (unless exception to fee schedule)
X-ray film revenue	Hospital assessments
Miscellaneous income	Donations made to other organizations
Donations received	CAH HIT adjustment for depreciation and interest
Revenue received for non-reimbursable cost centers	Advertising
Gain on disposal of fixed assets	Losses on disposal of fixed assets

Cost Reporting Strategies

Worksheet A-8 Advertising Adjustment Analysis

	Allowable	Nonallowable	Don't Know???
Fund-raising			
Recruiting medical paramedical, administrative, and clerical personnel			
Informational listing (yellow pages)			
Informational materials about the provider's operation			
TV advertisement for new service			
General public ads which seek to increase patient utilization of services			
General ads designed to invite physicians to utilize a provider's facility			
Presentation of good public image and related to patient care			
Rural health clinic advertising (special exception)			

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Cost Reporting Strategies

Required to offset interest income to the extent of interest expense except for . . .

Funded Depreciation and
Non-Comingled Contributions

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Cost Reporting Strategies

Funded Depreciation
Worksheet S-2 Part II Line 29

- Funds set aside for the acquisition of depreciable assets used to render patient care or for other capital purposes related to patient care
- Accounts designated as funded depreciation MUST be approved by the Board of Directors and documented in the Board minutes
- Document withdrawals from funded depreciation accounts to support acquisitions of depreciable assets
- Deposits must be held for six months prior to being withdrawn for capital acquisitions

Cost Reporting Strategies

Unnecessary Borrowing

Funded depreciation must be used before additional dollars are borrowed; otherwise, interest expense on that portion of the borrowing is disallowed on Worksheet A-8.

Worksheet A-8-1

Worksheet A-8-1- Related Organizations

Related parties included on worksheet A-8-1 are organizations related to a hospital by common ownership or control.

The types of cost include:

- Services
- Facilities
- Supplies

The actual cost is reported on worksheet A-8-1.

Worksheet A-8-2

Worksheet A-8-2 - Physician Cost

Worksheet A-8-2 calculates allowable provider-based physician costs.

- Total remuneration (salaries, certain benefits, contracted services) is split into two components:
  1. Professional component – services provided directly to patients
  2. Provider component – services provided to support patients such as availability/on-call, directorships, etc.

Worksheet A-8-2 - Physician Cost

- Report total remuneration (salaries, benefits*, contracted services) in column 3
- Report professional component in column 4
- Report provider administrative costs and ER availability in column 5

Health Financial Systems | SAMPLE CAH HOSPITAL | In Lieu of Form CMS-2552-10

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: XX13XX | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 12/18/2014 9:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,000,000	400,000	600,000	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	100,000	100,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,100,000	500,000	600,000		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

*Are certain benefits of employed physicians not required to be offset?

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Worksheet A-8-2 - ED Availability Requirements

- Emergency department (ED) logs or time study
- Contract language addressing non-patient-related time
- 30-minute physician response time to emergency departments (do not need to be on premises)

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Cost Reporting Strategies

- Worksheet A-8-2: Reporting provider-based physician costs
- Professional expenses reimbursed on a fee schedule must be removed from the cost report, except for professional expenses in a non-reimbursable cost center, such as a free standing clinic.
  - Have all professional fees been properly identified, such as ER, OR, EKG, radiology, lab, etc.?
  - A portion of professional fees may be allowable for standby time and/or on-call time with proper documentation. This portion of time is referred to as "provider" time.
  - The most common "provider" time is related to standby time for ER.
  - Is the hospital putting forth extra effort to properly capture the split of ER time between "professional" time and "provider" time?
  - If you pay for on-call OR coverage, this time may also be allowable as "provider" time depending on circumstances and MAC.
  - Medicare contractor will require documentation to support "provider" time identified on cost report worksheet A-8-2.

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Cost Reporting Strategies

Proper documentation of "provider component" time:

- Time study requirements from the Provider Reimbursement Manual are as follows:
  - Must submit written plan to intermediary no later than 90 days prior to start of cost reporting period
  - One full work week each month of the year
  - Must use alternating weeks (i.e., Week 1 in 1st month, Week 2 in 2nd month, etc.)
  - Time study must be signed by the physician

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Cost Reporting Strategies

Emergency Room Physician Time Study
SAMPLE

Physician Name: _____ Date: _____

Physician Signature: _____

To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.

		Part A - Provider Component					Part B - Professional Component	
		Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability [a]	Patient Services	Documentation
0:00	0:15							
0:15	0:30							
0:30	0:45							
0:45	1:00							
1:00	1:15							
1:15	1:30							
1:30	1:45							
1:45	2:00							

a Emergency Room Availability. For CAHs, this includes on-call time not on-site at the facility. Individual must not be performing any health care services at another location at the same time.

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Cost Reporting Strategies

Alternatives to required time study:

- Time study consisting of two two-week time studies for physicians (alternating weeks) and one week per month for midlevel practitioners
- Time study consisting of one week per quarter, alternating weeks
- ER Log

Approval from your Medicare contractor REQUIRED

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Cost Reporting Strategies

Recommended List of Items to Maintain

- Signed contract including ER on-call or availability with provider or provider group.
- Evidence that hospital evaluated alternative methods for ER coverage before selecting current method.
- Signed allocation agreement - Exhibit 1 of CMS 339.

(Source: PRM 2109)

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Cost Reporting Strategies

- Calculating ER professional component on Worksheet A-8-2 of Medicare cost report:

$$\frac{\text{Professional Component (column 4)}}{\text{Total Remuneration (column 3)}}$$

What is your percent?

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Cost Reporting Strategies

What would happen if some of these percentages changed?

Cost Reporting Strategies

- **Example of decreasing professional component percentage**

Professional/Provider Components	50/50	49/51	45/55	40/60
Total ER provider costs	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ 2,000,000
Professional component	$ 1,000,000	$ 980,000	$ 900,000	$ 800,000
Provider component	$ 1,000,000	$ 1,020,000	$ 1,100,000	$ 1,200,000
Impact of change from 50/50 split - additional reimbursement	$ -	$ 4,200	$ 20,900	$ 41,700

As the provider component goes up, the cost-to-charge ratio increases.

Impact will vary depending on Medicare volumes in the emergency room and in the hospital.

Medicare utilization of this emergency room is 20.8%.

Worksheet A-8-3

Worksheet A-8-3 - Purchased PT, OT, ST, RT

- Report only contracted PT, OT, ST, and RT
- Employed therapists are exempt from reasonable cost limits
- Reasonable cost is determined based on hourly limits and other factors
- Costs in excess of limits are eliminated on worksheet A-8

Worksheet A Series - Summary

Worksheet A Lines

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES — Provider CCN: XX1XX — Period: From 01/01/2014 To 12/31/2014 — Worksheet A — Date/Time Pre 12/18/2014 9:

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expenses For Allocation		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00		
	GENERAL SERVICE COST CENTERS									
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1,400,000	1,400,000	150,000	1,550,000	-20,000	1,530,000		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	600,000	600,000	-75,000	525,000		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2,000,000	2,000,000	0	2,000,000	0	2,000,000		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1,100,000	1,100,000	2,200,000	0	2,200,000	-65,000	2,135,000		5.00
7.00	00700 OPERATION OF PLANT	200,000	500,000	700,000	0	700,000	0	700,000		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	75,000	10,000	85,000	0	85,000	0	85,000		8.00
9.00	00900 HOUSEKEEPING	275,000	60,000	335,000	0	335,000	0	335,000		9.00
10.00	01000 DIETARY	200,000	430,000	630,000	0	630,000	-30,000	600,000		10.00
11.00	01100 CAFETERIA	0	0	0	0	0	0	0		11.00
16.00	01600 MEDICAL RECORDS & LIBRARY	500,000	130,000	630,000	0	630,000	0	630,000		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000 ADULTS & PEDIATRICS	920,000	100,000	1,020,000	0	1,020,000	-100,000	920,000		30.00
44.00	04400 SKILLED NURSING FACILITY	1,300,000	100,000	1,400,000	0	1,400,000	0	1,400,000		44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	0	0		45.00
	ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATING ROOM	200,000	400,000	600,000	0	600,000	0	600,000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	260,000	700,000	960,000	0	960,000	0	960,000		54.00
60.00	06000 LABORATORY	300,000	480,000	780,000	0	780,000	0	780,000		60.00
66.00	06600 PHYSICAL THERAPY	300,000	100,000	400,000	0	400,000	0	400,000		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40,000	100,000	140,000	0	140,000	0	140,000		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	250,000	750,000	1,000,000	0	1,000,000	0	1,000,000		73.00
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800 RURAL HEALTH CLINIC	1,000,000	600,000	1,600,000	0	1,600,000	0	1,600,000		88.00
91.00	09100 EMERGENCY	1,200,000	100,000	1,300,000	0	1,300,000	-400,000	900,000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)									92.00
	SPECIAL PURPOSE COST CENTERS									
113.00	11300 INTEREST EXPENSE		750,000	750,000	-750,000	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,120,000	9,810,000	17,930,000	0	17,930,000	-690,000	17,240,000		118.00
	NONREIMBURSABLE COST CENTERS									
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,000	0	30,000	0	30,000	0	30,000		190.00
200.00	TOTAL (SUM OF LINES 118-199)	8,150,000	9,810,000	17,960,000	0	17,960,000	-690,000	17,270,000		200.00

Overhead Cost Centers

Revenue Producing Cost Centers

Non-reimburseable Cost Centers

Expense Elimination

Worksheet A - Summary of Column 7 Costs

Information from Sample CAH Hospital Medicare cost report:

	Cost Report	Percent
Overhead cost centers	$ 8,540,000	49%
Revenue-producing cost centers:		
Cost-reimbursed cost centers	7,300,000	42%
PPS-reimbursed cost centers	1,400,000	8%
Non-reimbursable cost centers	30,000	1%
	$ 17,270,000	100%

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Worksheet B Part I

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Worksheet B - Allocation of Overhead Costs

- Allocation of overhead costs to revenue-producing and non-reimbursable cost centers/departments using statistics.
- Costs cannot be allocated to an "earlier" cost center.
- The order of the allocation cannot be changed.
- Overhead departments include:
  - Capital-related costs – Depreciation and interest expense
  - Employee benefits
  - Administration and general
  - Plant and maintenance
  - Laundry
  - Housekeeping
  - Dietary
  - Cafeteria
  - Nurse administration
  - Medical records

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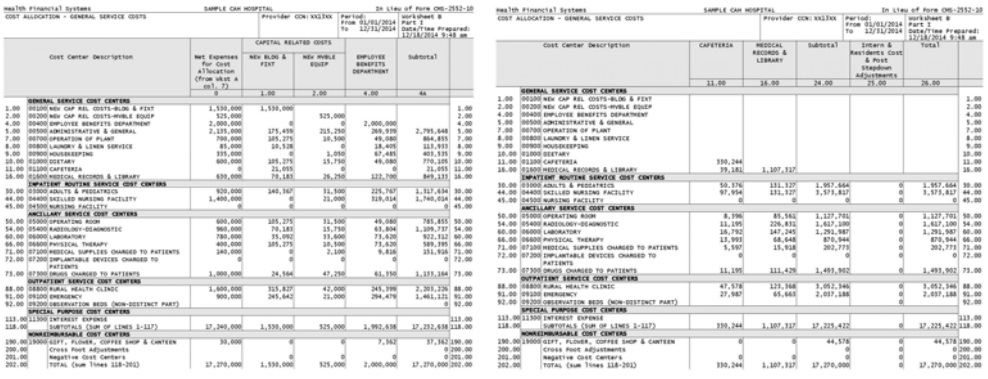
Worksheet B, Part I - Allocation of All Costs

- Column 0 equals Worksheet A Column 7
- Column 26 equals Column 0 in total with no costs reported on Lines 1 through 23



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Worksheet B-1

Cost Reporting Strategies

Examination of Conscience

When was the last time the statistics were updated in the cost report?

- Every year?
- Every other year?
- When my cost report preparer makes me?
- Never?

Cost Reporting Strategies

- Verify that each department included in an overhead department's statistic actually provides support services to that department
- What are common questions to ask when reviewing Worksheet B-1 (examples):
  - Does housekeeping clean the gift shop or the ambulance garage?
  - Is the nursery receiving an allocation from dietary?
  - How are physician benefits allocated?
  - Does central supply/purchasing order for all departments or do some departments do their own ordering (i.e., lab, pharmacy, etc.)?
  - Does maintenance provide services to leased buildings?
- Consider directly assigning housekeeping or maintenance costs to off-site nonallowable department (i.e., medical office building) only with a proper trail and support for Medicare

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Cost Reporting Strategies

Statistic Considerations

Square Feet:

- Update annually based on square footage changes.
  - Should be weighted based on date of change
- Did you know there are two square footage statistics?
  - Gross square footage includes hallways and common areas
  - Net square footage excludes hallways and common areas
  - Consider evaluating both methods
- Do not use gross square footage for part of the building and net square footage for other parts of the building. Maintain **consistency**.

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Cost Reporting Strategies

Statistic Considerations

Depreciation Expense:

- Tie to trial balance
- Depreciation expense:
  - Include interest and insurance expense related to equipment

Time Study:

- Update annually to match operations
- Meet time study requirements as previously discussed

Cost Reporting Strategies

Statistic Considerations

Gross Salaries:

- Tie to trial balance and:
  - Include all A-6 reclassifications that affect salaries
  - Do not include the salary statistic for any department where employee benefits are directly assigned

Cost Reporting Strategies

Statistic Considerations

FTEs (Including Nursing FTEs):

- Agree to annual payroll records
- Challenge whether the FTE uses the department
- Review reasonableness of FTEs per department (i.e., Nursing Admin)

Accumulated Costs:

- Calculated by cost report software

Cost Reporting Strategies

Statistic Considerations

Laundry Pounds:

- Accumulate annually so that statistic represents current year operations
- If using a third party, make sure you get pounds, not pieces

Meals:

- Accumulate annually so that statistic represents current year operations
- Statistic should not exceed patient days times three meals a day

Cost Reporting Strategies

Statistic Considerations

Patient Days:

- Agree to annual records
- Exclude nursery days

Costed Requisitions:

- Tie to internal records

Gross Patient Revenue:

- Typically includes professional revenue so it will not tie to Worksheet C

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Cost Reporting Strategies

Statistic Bases

Cost Center/Department	Simplified Method	Standard Recommendation
Building and Fixtures	Square Feet	Square Feet
Movable Equipment	Square Feet	Depreciation Expense or Square Feet
Maintenance & Repairs	Square Feet	Square Feet
Operation of Plant	Square Feet	Square Feet
Housekeeping	Square Feet	Square Feet or Time Study
Employee Benefits	Salaries	Gross Salaries
Cafeteria	Salaries	FTEs
Administrative and General	Accumulated Costs	Accumulated Costs
Laundry and Linen	Patient Days	Laundry Pounds
Dietary	Patient Days	Meals
Social Service	Patient Days	Time Study or Patient Days
Nursing Administration	Nursing Salaries	Nursing FTEs
Central Services	Costed Requisitions	Costed Requisitions
Pharmacy	Costed Requisitions	Costed Requisitions
Medical Records	Gross Patient Revenue	Gross Patient Revenue or Time Study

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Cost Reporting Strategies

Simplified cost method:

- ✓ Uses standard cost centers and prescribed statistics (no changes allowed)
- ✓ Less time and cost to accumulate statistics
- ✓ Prior approval must be received (90 days prior to the end of the cost reporting period), unless first year (period) as a CAH
- ✓ Once elected, must continue to use simplified method for no less than three years, unless a change of ownership occurs

Cost Reporting Strategies

Analyze financial impact of fragmented cost centers:

- Certain cost centers can be fragmented to allow for more accurate cost allocation:
  - ✓ Prior approval is needed from intermediary
  - ✓ Must submit 90 days prior to end of cost reporting period
  - ✓ Eliminates allocation of costs to areas not benefited
    - ~ Fragmenting certain administrative functions can result in less cost allocation to the non-cost-reimbursed and non-reimbursable cost centers

Cost Reporting Strategies

Fragmented Cost Centers:

- Buildings and fixtures to separately identify new building additions
- Administrative and general

Cost Center	Allocation Statistic
√ Communications	√ Number of phones
√ Data processing	√ Computers/processing time
√ Business office	√ Patient service revenue
√ Other A & G	√ Accumulated cost

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Worksheet B Series - Summary

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Fully Allocated Costs - Worksheet B, Part I

Line #	Dept.	Wks A, Col 7	Allocations from General Service Cost Centers	Total Fully Allocated Costs, Wks B, Part I, Col 26	% of Costs Allocated
	General Service Cost Centers				
1	New Capital-Bldg & Fixt	1,530,000	(1,530,000)	-	
2	New Capital-Equip	525,000	(525,000)	-	
4	Employee Benefits	2,000,000	(2,000,000)	-	
5	Administrative & General	2,135,000	(2,135,000)	-	
7	Operation of Plant	700,000	(700,000)	-	
8	Laundry & Linen Service	85,000	(85,000)	-	
9	Housekeeping	335,000	(335,000)	-	
10	Dietary	600,000	(600,000)	-	
16	Medical Records & Library	630,000	(630,000)	-	
	Inpatient Routine Service Cost Centers				
30	Adults & Pediatrics	920,000	1,037,700	1,957,700	53%
44	Skilled Nursing Facility	1,400,000	2,173,800	3,573,800	61%
	Ancillary Service Cost Centers				
50	Operating room	600,000	527,700	1,127,700	47%
54	Radiology-Diagnostic	960,000	657,100	1,617,100	41%
60	Laboratory	780,000	512,000	1,292,000	40%
66	Physical Therapy	400,000	470,900	870,900	54%
71	Medical Supplies Charged to Patients	140,000	62,800	202,800	31%
73	Drugs Charged to Patients	1,000,000	493,900	1,493,900	33%
	Outpatient Service Cost Centers				
88	Rural Health Clinic	1,600,000	1,452,300	3,052,300	48%
91	Emergency	900,000	1,137,200	2,037,200	56%
	Nonreimbursable Cost Centers				
	Subtotal	17,240,000	(14,600)	17,225,400	
190	Gift, Flower, Coffee Shop & Canteen	30,000	14,600	44,600	33%
	Total	17,270,000	-	17,270,000	

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Worksheet C

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Worksheet C - Cost-to-Charge Ratio

Worksheet C reports gross patient service revenue by cost center/department:

- Cost-to-charge ratio is calculated
- Cost-to-charge ratio used for ancillary reimbursement
- Key concept: Matching of revenue and expenses

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES — Provider CCN: XX13XX — Period: From 01/01/2014 To 12/31/2014 — Worksheet C Part I Date/Time Prepared: 12/18/2014 9:48 am
Title XVIII — Hospital — Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,957,664		1,957,664	0	1,957,664	30.00
44.00	04400	SKILLED NURSING FACILITY	3,573,817		3,573,817	0	3,573,817	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,127,701		1,127,701	0	1,127,701	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,617,100		1,617,100	0	1,617,100	54.00
60.00	06000	LABORATORY	1,291,987		1,291,987	0	1,291,987	60.00
66.00	06600	PHYSICAL THERAPY	870,944	0	870,944	0	870,944	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	202,773		202,773	0	202,773	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,493,902		1,493,902	0	1,493,902	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,052,346		3,052,346	0	3,052,346	88.00
91.00	09100	EMERGENCY	2,037,188		2,037,188	0	2,037,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	243,711		243,711		243,711	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,469,133	0	17,469,133	0	17,469,133	200.00
201.00		Less Observation Beds	243,711		243,711		243,711	201.00
202.00		Total (see instructions)	17,225,422	0	17,225,422	0	17,225,422	202.00

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Worksheet C - Cost-to-Charge Ratio

- Column 6 and 7 equal the hospital's inpatient and outpatient service revenue per the general ledger, less any revenue billed for professional services
- Column 8 total must be reconciled to internal or audited financial statements
- Cost-to-charge ratios are computed for ancillary departments (Column 9)

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES — Provider CCN: XX13XX — Period: From 01/01/2014 To 12/31/2014 — Worksheet C Part I Date/Time Prepared: 12/18/2014 9:48 am
Title XVIII — Hospital — Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,600,000		2,600,000			30.00
44.00	04400	SKILLED NURSING FACILITY	3,300,000		3,300,000			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,000	1,900,000	2,150,000	0.524512	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400,000	5,300,000	5,700,000	0.283702	0.000000	54.00
60.00	06000	LABORATORY	400,000	3,300,000	3,700,000	0.349186	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	425,000	1,300,000	1,725,000	0.504895	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,000	220,000	400,000	0.506933	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	500,000	2,300,000	2,800,000	0.533536	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,100,000	3,100,000			88.00
91.00	09100	EMERGENCY	50,000	1,600,000	1,650,000	1.234659	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,000	600,000	700,000	0.348159	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,205,000	19,620,000	27,825,000			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,205,000	19,620,000	27,825,000			202.00

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Cost Reporting Strategies

- All professional services reimbursed on a fee schedule must be eliminated on Worksheet C or reimbursement will be understated
  - Emergency room physicians
  - Anesthetist/CRNA (if not cost reimbursed)
  - Provider-based clinic physicians
  - Radiologist
  - Etc.
- Remember - Grouping of revenue must match grouping of expense

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Cost Reporting Strategies

Department	Sample Cost-to-Charge Ratio
Operating room	.678414
Radiology - Diagnostic	.358009
Laboratory	.700380
Respiratory therapy	.657865
Physical therapy	.834908
Medical supplies charged to patients	.313127
Implants charged to patients	.300117
Drugs charged to patients	.376038
Clinic	1.137843
Emergency	.911530
Observation beds (nondistinct part)	.301296

Note: Total charges on Worksheet C exclude professional fees

- Cost-to-charge ratio over 1.0 means costs exceed charges.
- Cost-to-charge ratios greater than 1.0 or a change of greater than 10% compared to the prior year may be questioned by the Medicare contractor.
- Cost-to-charge ratio near zero means charges greatly exceed cost.
- Cost-to-charge ratios should be comparable to the prior filed cost report or an explanation of the change should be available.

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Cost Reporting Strategies

Typical Departments With Cost-to-Charge Ratio Over 1.0:

1. Low volume departments such as labor and delivery or speech therapy
2. High cost departments such as emergency room, clinic, and observation
3. Cost report preparation errors such as:
   - Anesthesia – Calculation of professional component costs (not removed)
   - Medical supplies – Expense reported in medical supply department while charges reported in department utilizing the supply
   - Laboratory – Lab gross-up not completed
4. Start-up departments such as operating room with a new surgeon

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Worksheet D & E

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Worksheet D Series - Determines Medicare's Costs

- Worksheet D Series calculates Medicare's cost for services provided to Medicare patients
- Applies cost-to-charge ratio by department from Worksheet C to Medicare charges to estimate the Medicare cost
- Medicare patient days, charges, payments, and other processed claims information are provided by Medicare on the provider statistical and reimbursement (PS&R) report
- Group PS&R revenue by revenue code to match cost centers where related revenue and expenses recognized on Worksheet A series and Worksheet C series

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Medicare PS&R

- Suggestions for running PS&R:
  - Attempt to run reports well in advance (at least 45 days) to ensure you can access data needed for your cost report
  - For cost report PS&R, we suggest you use a paid-through date that is as close as possible to the due date of your cost report (be sure to review that claim billing is not behind or the final settlement could change significantly)
  - Passwords in the online PS&R system expire every 60 days

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Medicare PS&R

Cost Report Worksheet	Related PS&R Schedule
	Statistical Data
S-3	Reports 110, 118, 180, 210, 399, 710
	Charges
D-3 Hospital	Report 110 – Inpatient Part A (Charges)
D-3 SNF	Report 210 – SNF - Inpatient Part A (Charges)
D-3 S/B SNF	Report 180 – Swing bed SNF (Charges)
D Part V	Report 850 – Outpatient (Charges)
S-4	Report 399 – Home health

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Medicare PS&R

Cost Report Worksheet	Related PS&R Schedule
	Payments
E-1, Hospital, Col 2	Report 110 – Inpatient Part A (net reimbursement)
E-1, Hospital, Col 4	Report 850 – Outpatient (net reimbursement)
E-1, SNF, Col 2	Report 210 – Inpatient Part A (net reimbursement)
E-1, S/B - SNF, Col 2	Report 180 – Swing bed SNF (net reimbursement)
M-5	Report 710 – Rural health clinic (net reimbursement)
H-4	Report 399 – Home health

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Worksheet D Part V (Outpatient)
Worksheet D-3 (Inpatient, SNF, Swing Bed)

Ancillary Hospital Costs Allocated to Medicare Services

- Cost-to-charge ratio from Worksheet C
- Outpatient Medicare charges from PS&R
- Ratio times charge equals Medicare cost

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST — Provider CCN: XX13XX — Period: From 01/01/2014 To 12/31/2014 — Worksheet D Part V Date/Time Prepared: 12/18/2014 9:48 am

Title XVIII — Hospital

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (See inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (See inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (See inst.)	Costs: PPS Services (See inst.)		Costs: Cost Reimbursed Services Subject To Ded. & Coins. (See inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (See inst.)	
		1.00	2.00	3.00	4.00	5.00		6.00	7.00	
	ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATING ROOM	0.524512	0	750,000	0	0	50.00	393,384	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283702	0	2,000,000	0	0	54.00	567,404	0	54.00
60.00	06000 LABORATORY	0.349186	0	1,400,000	0	0	60.00	488,860	0	60.00
66.00	06600 PHYSICAL THERAPY	0.504895	0	300,000	0	0	66.00	151,469	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.506933	0	50,000	0	0	71.00	25,347	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.533536	0	400,000	1,000	0	73.00	213,414	534	73.00
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00	0	0	88.00
91.00	09100 EMERGENCY	1.234659	0	700,000	0	0	91.00	864,261	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.348159	0	300,000	0	0	92.00	104,448	0	92.00
200.00	Subtotal (see instructions)		0	5,900,000	1,000	0	200.00	2,808,587	534	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	5,900,000	1,000	0	202.00	2,808,587	534	202.00

Overall Cost-to-charge ratio: 47.6%
2,808,587 / 5,900,000 before 101%

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Why Is Grouping of Revenue Codes Important?

- Department Report by Revenue Code
  - Assists the cost report preparer in identifying which department the charges on the PS&R are related to
  - The report matches revenue to the appropriate revenue codes and departments
  - Using a department report by revenue code can increase the accuracy of the cost report

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Why Is Grouping of Revenue Codes Important?

Example: Where is IV therapy done in the Hospital? (Assume nursing charge is billed with 260 revenue code.) What impact could this have on CAH Medicare reimbursement?

Method of Assignment	Cost Center Assignment	CCR (Worksheet C)		Charges Billed From PS&R Revenue Code 260		Calculated Reimbursement
Medicare standard assignment	Line 73 Pharmacy	0.532216	X	100,000	=	$ 53,222
Hospital specific service location	Line 91 Emergency Room	1.425308	X	100,000	=	142,531
Difference in calculated reimbursement						$ (89,309)

Worksheet D-1, Hospital

Health Financial Systems — SAMPLE CAH HOSPITAL — In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST — Provider CCN: XX1YYX — Period: From 01/01/2014 To 12/31/2014 — Worksheet D-1 — Date/Time Prepared: 12/18/2014 9:48 am

	Cost Center Description	Title XVIII	Hospital	
			Cost	
			1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,275	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,475	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,200	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		720	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		80	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		725	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		600	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,957,664	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		12,400	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		650,486	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,307,178	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,307,178	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		886.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		642,517	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		642,517	41.00

$1,957,664 (1) less NF SB Cost of $12,400 = $1,945,264 / (2,275 I/P days – 80 NF SB days) = $886.23 (A)

SNF SB 720 days x $886.23 = $638,085 (B)

NF SB: 80 days x $155 = $12,400 (B)

$650,486 Sum (B)'s = Total SB cost

(1) I/P routine allowable costs, Wks B, Part 1, Col 26

(B)'s

(A)

Worksheet D-1 Medicare Line 38, Inpatient Routine Service Cost Per Diem

How to Determine Routine Medicare Utilization

	Total Days	Medicare Days	Medicare Utilization
Routine	3,377	2,729	81%
	(A)	(B)	(B) / (A)

Total days include:

A & P	Worksheet S-3, Part I, Line 1, Col 8
Swing bed SNF	Worksheet S-3, Part I, Line 5, Col 8
Observation	Worksheet S-3, Part I, Line 28, Col 8

Medicare days include:

A & P	Worksheet S-3, Part I, Line 1, Col 6
Swing bed SNF	Worksheet S-3, Part I, Line 5, Col 6

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How to Determine Ancillary Medicare Utilization

	Ancillary Department	Wks C, Col 8 Total Charges	Medicare Charges Wks D, V O/P	Wks D-3 I/P	Wks D-3 Swing Bed	Total	Medicare Utilization	Wks C Cost-to-Charge Ratio
		(A)				(B)	(B) / (A)	
50	Operating room	$ 1,368,900	$ 427,400	$ 230,000	$ -	$ 657,400	48%	0.5074
53	Anesthesiology	531,300	177,000	105,000	-	282,000	53%	0.6516
54	Radiology	2,236,400	951,000	247,000	27,000	1,225,000	55%	0.3967
60	Laboratory	2,399,500	1,041,000	536,000	25,000	1,602,000	67%	0.3066
60.01	Blood	122,700	34,000	30,000	4,000	68,000	55%	0.2048
65	Respiratory therapy	579,100	123,000	241,000	31,000	395,000	68%	0.2178
66	Physical therapy	995,500	157,000	62,000	79,000	298,000	30%	0.4968
67	Occupational therapy	264,000	17,000	37,000	63,000	117,000	44%	0.3853
68	Speech therapy	73,800	11,000	4,000	1,500	16,500	22%	0.3039
69	Electrocardiology	416,000	76,000	82,000	700	158,700	38%	0.2209
71	Medical supplies charged to patient	1,712,600	332,000	733,000	109,000	1,174,000	69%	0.3477
73	Drugs charged to patients	60,800	11,000	31,000	4,300	46,300	76%	0.2310
91	Emergency	1,846,000	760,000	162,000	1,000	923,000	50%	0.4853
92	Observation beds	235,000	103,000	-	-	103,000	44%	0.4168
95	Ambulance	530,200	243,000	-	-	243,000	46%	0.4495
	Totals	$ 13,371,800	$ 4,463,400	$ 2,500,000	$ 345,500	$ 7,308,900	55%	

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Cost Reporting Strategies

If you had the ability to record expenses in any department on the previous slide, which one would you select?

- Anesthesiology?
- Drugs charged to patients?
- Laboratory?
- Other?

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Worksheet E Series - Medicare Settlements

Medicare settlements:

101% of costs (routine and ancillary)
Less:
- Deductible
- Coinsurance

Plus + Medicare bad debts
Less – Sequestration adjustment (2% of 101% of cost less deductible and coinsurance lines)

= Total Medicare reimbursable cost
Less – Payments received from Medicare (Worksheet E-1)

= Medicare settlement

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Medicare Bad Debts

Bad debts are allowable if:

- Amount pertains to uncollectible Medicare deductible and coinsurance amounts
- Does not relate to physician professional services
- Only for Traditional Medicare bad debts (do not include Medicare HMO beneficiaries)
- Unless patient has been determined to be indigent, write-off should not be less than 120 days after first billing to beneficiary
- Amount written off within cost reporting period and considered worthless when returned from collection agency (if sent to a collection agency)
- Collection efforts must be the same for all payor types
- Any recoveries of bad debts claimed in prior years are offset against amounts claimed in current year

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Medicare Bad Debts

May be claimed without collection effort if:

- Medicare/Medicaid crossover claim, except Medicare has a must bill policy - Therefore, if you claim a Medicare bad debt, it must be billed to the State even if you know it will not be paid
- Indigent patients with supporting proof of indigence
- Bankrupt patients with supporting proof of bankruptcy

Bad debts currently reimbursed at 65% of allowable cost

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Medicare Bad Debts

Documentation required to support claimed amounts may include:

- Medicare remittance advice
- Medicaid remittance advice
- Supplementary insurance remittance advice
- Copy of UB
- Patient history information
- Copies of bills sent to patients
- Documentation supporting collection efforts (i.e., considered worthless when returned from collection agency)
- Electronic listing of bad debts claimed that includes patient name, Medicare number, dates of service, indigence, write-off date, amounts, etc.

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Worksheet G

Financial Statements

G	Balance sheet
G-1	Fund balance
G-2	Patient revenues
G-3	Revenue & expense

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Clinic Services

Clinic Services

Types of Clinics

- Free standing clinic
- Free standing rural health clinic
- Provider-based clinic
- Provider-based rural health clinic

Clinic Services

Free Standing vs. Provider-Based

Free Standing Clinic – A medical clinic operating as its own entity. A free standing clinic may be owned by another entity such as a hospital or by a group of physicians.

Provider-Based Clinic – A clinic owned and operated as an "outpatient department" of the hospital similar to other hospital departments such as x-ray, laboratory, ER, etc.

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How Does a Provider-Based Clinic Work?

 135

Provider-Based Clinic - Key Concepts

There are four general criteria that apply to all sites seeking provider-based status:

- ***Common licensure*** – meaning the operations of the department are operating as a department of the hospital it is considered a part of.
- ***Clinical integration*** – meaning the clinic records and activities are integrated as with any other hospital department with reporting responsibility of the department directly to hospital leadership.
- ***Financial integration*** – meaning the financial and billing activities of the provider-based department are included in the activities of the hospital.
- ***Public awareness*** – meaning the provider-based department is presented to the public as a department of the hospital.

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How Does Provider-Based Billing Work?

- Financial and billing example for CPT 99213, a common midlevel evaluation and management code:
  - Patients, other than Medicare patients, are billed on CMS Form 1500 as a global service as a free standing clinic.
  - Medicare patients are billed differently:
    - The professional service is billed as site-of-service facility with a Medicare reimbursement rate of $49.87 compared to the free standing clinic rate of $70.46.
    - PPS Hospital: The technical service is billed and reimbursed separately as an ambulatory procedure code (APC) payment in the amount of $85.98.
    - CAH Hospital: The technical service is billed and reimbursed separately based on available cost.

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How Does Provider-Based Billing Work?

Medicare Reimbursement Example for Provider-Based Clinic vs. Free Standing Clinic

PPS Hospital Sample

Sample Service (CPT 99213)	9913 Professional	APC GO463 Facility	99213 Global (or Total)
Free standing clinic			70.46
Provider-based department of PPS hospital	49.87	85.98	135.85
Net increase in reimbursement			65.39

CAH Hospital Sample

Sample Service (CPT 99213)	9913 Professional	CCR of Clinic Dept. Facility	99213 Global (or Total)
Free standing clinic			70.46
Provider-based department of CAH hospital	49.87	87.50	137.37
Net increase in reimbursement			66.91

This example reflects the difference in Medicare reimbursement between a free standing clinic and a provider-based department of a hospital for both a PPS and CAH hospital.

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How Does a Provider-Based Rural Health Clinic Work?

 139

Provider-Based RHC - Key Concepts

In general, the requirements are as follows:

- Located in a "rural" and "underserved" community.
- Must employ at least one nurse practitioner (NP) or physician assistant (PA).
- Required to be staffed by NP or PA or certified nurse midwife (CNM) who must be on site to see patients at least 50% of the time clinic is open.
- Other staff may work under contract.
- A physician must supervise each NP, PA, or CNM consistent with state and federal law.
- Capable of delivering outpatient primary care services (direct services, basic lab services, emergency services).
- Maintain a patient health record system and deliver health care services under the guidance of written policies and procedures.

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RHC Services

- Physician services
- Services of nonphysician practitioners (NPP), which include physician assistants, nurse practitioners, and certified nurse midwives (does not include clinical nurse specialists)
- Services and supplies incident to Physicians and NPP
- Visiting nurse services to the homebound
- Clinical psychologist and clinical social worker services
- Services and supplies incident to clinical psychologist and clinical social workers
- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective 1/1/05

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How Does RHC Billing Work?

- Medicare reimbursement (and in some states Medicaid as well) in a provider-based RHC, for both the professional and technical services, is based on allowable costs.
- On an interim basis, a visit-based reimbursement rate is established, with final settlement based on the filing and review of Medicare and, if applicable, Medicaid cost reports.
- Medicare has established annual minimum productivity thresholds for midlevel providers and physicians. If providers do not meet minimum visit thresholds, the allowable costs are divided by the minimum productivity thresholds, thus reducing reimbursable cost to the extent productivity standards are not met.
- The billing process for payors other than Medicare is consistent with a free standing clinic.

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How Does Provider-Based RHC Billing Work?

Medicare Reimbursement Example for Provider-Based Clinic or Provider-Based RHC vs. Free Standing Clinic

Sample Service (CPT 99213)	9913 Professional	APC GO463 Facility	99213 Global (or Total)
Free standing clinic visit			70.46
Provider-based clinic - PPS hospital	49.87	85.98	135.85
Provider-based clinic - CAH hospital	49.87	87.50	137.37
Provider-based rural health clinic			222.35

This example reflects the difference in Medicare reimbursement between a free standing clinic and a provider-based department of a hospital.

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Clinic Services

Medicare Reimbursement – Summary:

- Free Standing Clinic: Fee schedule reimbursement
- Provider-Based Clinic (treat as a hospital department):
  - Professional Component: Fee schedule reimbursement
  - Facility Component: Cost-based reimbursement (CAH)/APC (PPS)
- Rural Health Clinic (RHC): Cost-based reimbursement
  - Independent RHC: Cost-based up to annual per encounter limit
  - Provider-Based RHC: Cost-based without per encounter limit, if hospital the RHC is provider-based to is less than 50 beds
  - Both types of RHCs are subject to a provider productivity standard to receive full cost reimbursement or rate per encounter

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Worksheet M Series

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Worksheet M Series

RHC Cost Report Components

- Trial Balance of Expenses
- Reclassification and Adjustment of Trial Balance of Expenses
  - Reclassifications
  - Adjustments
  - Related-party adjustments
- RHC Provider Statistics
- Flu/PPV Vaccine Costs
- Visits
- Overhead
- Determination of Medicare Reimbursement and Payments

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Worksheet M Series

Cost Report Requires Separation of Staff Costs

- Health Care Staff Costs:
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Visiting Nurse
  - Other Nurse
  - Clinical Psychologist
  - Clinical Social Worker
- Facility Overhead Costs:
  - Office Staff
- Cost Other Than RHC Services:
  - Laboratory
  - Radiology
  - Hospital Services
  - Other

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Worksheet M Series

Cost Report Example

						:	NET
						:	EXPENSES
		COMPEN-	OTHER		RECLASS-	:	FOR
		SATION	COSTS	TOTAL	IFICATIONS	:	ALLOCATION
		1	2	3	4	:	7
	FACILITY HEALTH CARE STAFF COSTS					:	
1	Physician	850,000	150,000	1,000,000		:	1,000,000
2	Physician Assistant	120,000	40,000	160,000		:	160,000
3	Nurse Practitioner					:	
4	Visiting Nurse					:	
5	Other Nurse	175,000		175,000		:	175,000
6	Clinical Psychologist					:	
7	Clinical Social Worker					:	
8						:	
9	Other Facility Health Care Staff Costs					:	
10	Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	-	:	1,335,000

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Worksheet M Series

Identify Costs of Non-RHC Services

- Laboratory services
- Diagnostic radiology
- Hospital patients (inpatient/ER/ASC)
- Medical directorships
- Screening mammography services
- DME
- Ambulance services
- Prosthetic devices

  These costs may be allowable on the Hospital cost report for areas such as laboratory or radiology services if qualify as provider-based services; however, they are carved out of the RHC allowable costs when determining the rate per encounter.

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Worksheet M Series

Cost Report Requires Separation of FTEs and Visits

- Health Care Provider FTEs and Visits:
  - *Physician*
  - *Physician Assistant*
  - *Nurse Practitioner*
  - *Visiting Nurse*
  - *Clinical Psychologist*
  - *Clinical Social Worker*

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Worksheet M Series

Common Mistakes Calculating FTEs:

DO record FTE for clinic time only:

- *Time spent in the clinic*
- *Time with SNF patients*
- *Time with swing bed patients*

DO NOT include non-clinic time for FTE:

- *Hospital time (inpatient or outpatient)*
- *Administrative time*
- *Committee time*

Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

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Worksheet M Series

Sample Reconciliation of Provider FTE:

Clinical FTE	**0.70**
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	**1.00**

Worksheet M Series

RHC Encounters/Visits

"The term 'visit' is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered."
RHC Manual, Ch.504

Worksheet M Series

Common Mistakes Calculating RHC Visits:

- **DO** include all "visits" that:
  - Take place in the RHC during hours of operation,
  - Home visits, and
  - SNF visits for all payors.
  - Swing bed visits for all payors.
- **DO NOT** include the following "visits":
  - Hospital visits (either inpatient or outpatient visits) or
  - "Nurse-only" visits in the RHC setting.

Worksheet M Series

RHC Visits

- Counting of "visits" is easier said than done.
- Do not include the following in your visit count:
  - Units of service instead of visits
  - Non-visits (e.g., nurse-only 99211)
  - Non-RHC visits (e.g., hospital visits)
  - Non-billable visits (e.g., cash only)
- Remember: higher visits = lower cost per visit = lower rate!

Worksheet M Series

Productivity Standards:

- *Physician 4,200 visits annually for 1.0 FTE*
- *Midlevel 2,100 visits annually for 1.0 FTE*

Total visits used in calculation of cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard).

An exemption to the productivity standards may be requested on an annual basis; however, exemption requirements are vague and may be difficult to obtain. Need to show a unique circumstance as to why the standard should be reduced.

NOTE: **The cost report productivity standards cannot be manually adjusted. Therefore, if a provider only worked a portion of a year or if the cost report only represents a portion of a year, the FTE should be adjusted accordingly.**

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Medicare Cost Report – Sample Worksheet M-2

	Visits and Productivity Position	Number of FTEs	Total Visits	Productivity Standard	Minimum Visits	Greater of Total Visits or Minimum Visits
1	Physician	1.00	2,000	4,200	4,200	
2	Physician Assistant	-	-	2,100	-	
3	Nurse Practitioner	1.30	3,200	2,100	2,730	
4	Subtotal	2.30	5,200		6,930	6,930

	Visits and Productivity Position	Number of FTEs	Total Visits	Productivity Standard	Minimum Visits	Greater of Total Visits or Minimum Visits
1	Physician	0.70	2,000	4,200	2,940	
2	Physician Assistant	-	-	2,100	-	
3	Nurse Practitioner	1.30	3,200	2,100	2,730	
4	Subtotal	2.00	5,200		5,670	5,670

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Worksheet M Series

RHC Payment Rate Calculation

$$\frac{\textit{Allowable RHC Costs}}{\textit{Greater of Total Visits or Minimum Visits}} =$$

RHC Cost Per Encounter

(Not to exceed the maximum reimbursement limits if clinic is an independent rural health clinic.)

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Worksheet M Series

Allowable RHC Costs	$ 750,000	$ 750,000
Greater of Total Visits or Minimum Visits	6,930	5,670
RHC Cost per Encounter	$ 108	$ 132
Difference		$ 24
Medicare Visits		3,000
Increase in Reimbursement		$ 72,000

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Worksheet M Series

How many of you have Rural Health Clinics currently not meeting the RHC productivity standards?

Other Cost Report Worksheets

- H Series = Home Health
- K Series = Hospice
- I Series = Dialysis
- Subproviders = Psych, Acute Rehab, SNF
  - May require additional D and E Series worksheets

Useful Information

• Cost-to-charge ratios	W/S C
• Cost per day	W/S D-1
• Cost per visit (RHC)	W/S M-3
• Cost per visit (HHA)	W/S H-3
• Charges I/P & O/P	W/S C
• Patient days	W/S S-3
• FTEs	W/S S-3
• Direct cost by department	W/S A
• Allocated cost	W/S B, Part 1
• Statistical data	W/S B-1
• Medicare inpatient cost	W/S D-1
	W/S D-3
• Medicare outpatient cost	W/S D, Part V

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Recommended Questions for Review of Cost Report

- Do worksheets A and C reconcile to our internal or audited financial statements?
- Have we reviewed all miscellaneous revenue and expense accounts for any necessary A-8 cost adjustments?
- Have we captured all allowable costs from related parties (if any)?
- Have we summarized time studies for physicians or other departments in the current year?
- Do patient days reconcile to internal statistics or revenue reports?
- Have statistics on B-1 been reviewed for reasonableness?
- Are costs assigned or allocated to non-reimbursable cost centers appropriate (including cost centers such as nursery, labor and delivery, nursing home, etc.)?
- Are cost-to-charge ratios consistent and reasonable between years?
- Have professional fees been properly excluded from worksheet C?
- Have we reviewed FTEs and minimum visits in the rural health clinics (if applicable)?

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Questions?
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Thank you!
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